TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EAST TEXAS MEDICAL CENTER

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-15-3989-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this MDR to appeal for appropriate payment on this claim and to preserve our rights. HRA has been hired by EAST TEXAS MEDICAL CENTER audit their Workers Compensation Claims. We have found in this audit they have not paid what we determine is the correct amount per the APC allowable per the APC allowable per the new fee schedule that started 3/1/2008 for the following HCPC's: …

After your payment of $3,422.66, there is a balance due of $1,974.62."

Amount in Dispute: $1,974.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with Chapter 28 TAC §10.121, an investigation has been completed on your issue. The procedures in question, 70450, 71260, 72125, 72126 and 72128 all have Status indicators of Q3. Payment was consolidated into other procedures billed on the same day. Those procedures are 72141 and 74177 as indicated on the EOB with explanation "The final recommended reimbursement for CMS Hospital Outpatient APC composite is reflected on this line. (MCMP)."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2014	Outpatient Hospital Services	$1,974.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X206 – The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit appeal with EOP and documentation to support the relatedness of services rendered to the work related injury
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - Z652- Recommendation of payment has been on a procedure code which best describes services rendered
   - Z951 – Additional allowance not recommended per fee schedule, usual and customary guidelines and or provider's PPO contract
   - X396 – CPT or HCPC is required to determine if services are payable
   - W3 – Additional payment made on appeal/reconsideration
   - MOPS – Services reduced to the outpatient perspective payment system (OPPS)
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - MP86 – Recommended reimbursement is based on CMS Hospital Outpatient Composite APC

Issues

1. Is there an unresolved extent of injury issue?
2. Are the disputed services subject to a contract?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier initially denied date of service August 27, 2014 for "The service(s) is for a condition(s) which is not related to the covered work related injury." Review of the submitted documentation finds that the insurance carrier did not maintain this denial, making payment on billed services for these dates of service. Therefore, there is not an unresolved extent of injury issue relating to this dispute.
2. The insurance carrier denied the disputed services with reason code Z951 – "Additional allowance not recommended per fee schedule, usual and customary guidelines and or provider's PPO contract and P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."

   No documentation was found to support a contract between the insurance carrier and the provider for the disputed services. No documentation was presented to support a contracted fee agreement between the health care provider and an insurance network. No documentation was presented to support that the insurance carrier was contracted with the insurance network it alleges had negotiated a fee reduction with the health care provider. No documentation was presented to support that the insurance carrier had been granted access to the health care provider's alleged fee agreement with the network during the time the services were rendered. These payments reduction reasons are not supported. The disputed service will therefore be reviewed per applicable rules and guidelines.
3. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests

separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 36415 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80053 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85025 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85610 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85730 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $34.41. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $29.85. The non-labor related portion is 40% of the APC rate or $22.94. The sum of the labor and non-labor related amounts is $52.79. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $52.79. This amount multiplied by 200% yields a MAR of $105.58.
   - Procedure code 73030 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $34.41. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $29.85. The non-labor related portion is 40% of the APC rate or $22.94. The sum of the labor and non-labor related amounts is $52.79. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $52.79. This amount multiplied by 200% yields a MAR of $105.58.
   - Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the

charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 71260 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 74177 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $43.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.27. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $22.79. The non-labor related portion is 40% of the APC rate or $17.51. The sum of the labor and non-labor related amounts is $40.30. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $40.30. This amount multiplied by 200% yields a MAR of $80.60.
- Per Medicare policy, procedure code 96374 may not be reported with procedure code 72160 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96374 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0438, which, per OPPS

Addendum A, has a payment rate of $105.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $63.54. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $55.13. The non-labor related portion is 40% of the APC rate or $42.36. The sum of the labor and non-labor related amounts is $97.49. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $97.49. This amount multiplied by 200% yields a MAR of $194.98.

- Per Medicare policy, procedure code 96375 may not be reported with procedure code 71260 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96375 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $43.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.27. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $22.79. The non-labor related portion is 40% of the APC rate or $17.51. The sum of the labor and non-labor related amounts is $40.30 multiplied by 3 units is $120.90. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $120.90. This amount multiplied by 200% yields a MAR of $241.80.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $293.71. This amount multiplied by 60% yields an unadjusted labor-related amount of $176.23. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $152.90. The non-labor related portion is 40% of the APC rate or $117.48. The sum of the labor and non-labor related amounts is $270.38. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $270.38. This amount multiplied by 200% yields a MAR of $540.76.
- Procedure code 72141 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8007. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 72146 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8007. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the

charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 72148 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8007. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 70450, 71260, 72125, and 74177 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT procedure is performed on the same date of service as a "with contrast" CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which, per OPPS Addendum A, has a payment rate of $548.28. This amount multiplied by 60% yields an unadjusted labor-related amount of $328.97. This amount multiplied by the annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $285.41. The non-labor related portion is 40% of the APC rate or $219.31. The sum of the labor and non-labor related amounts is $504.72. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $504.72. This amount multiplied by 200% yields a MAR of $1,009.44.
- Procedure codes 72141, 72146, and 72148 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8007, for magnetic resonance imaging (MRI) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8007, which, per OPPS Addendum A, has a payment rate of $621.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $372.78. This amount multiplied by the

annual wage index for this facility of 0.8676 yields an adjusted labor-related amount of $323.42. The non-labor related portion is 40% of the APC rate or $248.52. The sum of the labor and non-labor related amounts is $571.94. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $571.94. This amount multiplied by 200% yields a MAR of $1,143.88.

5. The total allowable reimbursement for the services in dispute is $3,422.62. This amount less the amount previously paid by the insurance carrier of $3,422.66 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/30/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.